

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9218
Registrar's No. 2701

Registration District No. 7911

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Homer Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME HORACE FISHER
3. (b) If veteran, name war no
3. (c) Social Security No. 497-07-6795

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Jan 10 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 2 Days 8 If less than one day hr. min.

9. Birthplace Vicksburg Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Prod. Carrier

11. Industry or business Building Industry

12. Name Mimsey Fisher

13. Birthplace Crystal Springs Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Eldred Riggins

15. Birthplace Beaumont Texas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wilean Goodman

(b) Address 1426 Loughness St. New Orleans La

17. (a) Removal (b) Date thereof March 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East St. Louis Ill

18. (a) Signature of funeral director W. J. Marshall

(b) Address 2203 Maple East St. Louis Ill.

19. (a) MAR 22 1940 (b) J. J. Phelan
(If not a medical registrar) (If not a physician)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison
(c) City or town Madison NR
(If outside city or town limits, write "RURAL")
(d) Street No. 810 Jackson St.
(If rural, give location)
(e) If deceased born in foreign country — years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18
year 1940 hour 15 minute 15 P.M.

21. I hereby certify that I attended the deceased from —, 19—, to —, 19—;
that I last saw him alive on —, 19—;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy

Due to —

Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —

While at work? — (Specify type of sign) (e) Means of injury —

23. Signature W. J. Marshall (M. D. or other)

Address 2203 Maple East St. Louis Ill. Date signed 3.22.40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Robert H. Powell*

Licensed Embalmer No. *3402*

P. O. Address *3100 Franklin*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.